BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	File No.: 17-2001-126714
JAMES I. HONDA, M.D.	)	
	)	
Physician's and Surgeon's	)	
Certificate No. A 21748	)	
	)	
Respondent.	)	
	)	

DECISION

The attached Stipulation for Surrender of License is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California as its Decision in the above entitled matter.

This Decision shall become effective at **5:00 p.m. on** March 13, 2008.

IT IS SO ORDERED March 6, 2008.

Barbara Johnston
Executive Director

EDMUND G. BROWN JR., Attorney General
of the State of California
JOSE GUERRERO, Supervising
Deputy Attorney General
DAVID CARR, State Bar No. 131672
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: James I. Honda, M.D. 1321 N. Harbor Blvd., Suite 202 Fullerton, CA 92835 Physician's and Surgeon's Certificate No. A 21748, Respondent.	Case No. 17 2001 126714 **STIPULATION FOR SURRENDER OF LICENSE**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings, that the following matters are true:

1. Complainant David T. Thornton brought this action solely in his official capacity as the Executive Director of the Medical Board of California ("Medical Board" or "Board"). David T. Thornton is represented in this matter by Edmund G. Brown Jr, Attorney General of the State of California, through David Carr, Deputy Attorney General.

2. Respondent James I Honda, M.D. ("respondent") is represented in this matter by Davis, Grass, Goldstein & Housouer, through Stacy K. Brigham, Esq.

3. On or about August 6, 1965, the Medical Board issued Physician's and Surgeon's Certificate Number A 21748 to James I. Honda, M.D. This certificate, unless

renewed, will expire on September 30, 2008.

4. A Second Amended Accusation in Case No. was filed on August 31, 2006 before the Division of Medical Quality ("division"), Medical Board of California, Department of Consumer Affairs. A copy of the Accusation is attached as Exhibit A and incorporated by reference in this stipulation.

5. Respondent has reviewed this agreement with his attorneys and understands the nature of the charges and allegations in the Accusation and the effects of this Stipulation for Surrender of License.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing to contest the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; and the right to reconsideration and court review of an adverse decision.

7. For purposes of this stipulation, respondent voluntarily, knowingly, and intelligently waives and gives up each of the rights set forth above.

8. Respondent understands the nature of the charges alleged in the Accusation and that, if proven at hearing, such charges and allegations would constitute cause for imposing discipline upon his physician's and surgeon's certificate.

9. For the purpose of resolving Case No. 17 2001 126714 without the expense and uncertainty of further proceedings, respondent gives up his right, as set forth in paragraph 6, above, to contest that cause for discipline exists based on the charges in the Accusation and admits that if the matter were to proceed to hearing the Board could prove to a clear and convincing degree that cause for discipline exists in this case. Respondent agrees to surrender his physician's and surgeon's certificate for the division's formal acceptance.

10. All admissions and recitals contained in this stipulation are made solely for the purpose of settlement in this proceeding and for any other proceedings in which the Division of Medical Quality, Medical Board of California or other professional licensing agency

is involved, and shall not be admissible in any other criminal or civil proceedings.

11. Respondent understands that by signing this stipulation he is enabling the Division of Medical Quality to issue its order accepting the surrender of his license without further process. He understands and agrees that Medical Board's staff and counsel for complainant may communicate directly with the division regarding this stipulation without notice to or participation by respondent or his counsel. If the division fails to adopt this stipulation as its Order, the Stipulation for Surrender of License, except for this paragraph, shall be of no force or effect. The Stipulation for Surrender of License shall be inadmissible in any legal action between the parties and the division shall not be disqualified from further action by having considered this matter.

12. Upon acceptance of the stipulation by the division, respondent understands that he will no longer be permitted to practice as a physician in California.

13. Respondent fully understands and agrees that if he ever files an application for relicensure or reinstatement in the State of California, the division shall treat it as a petition for reinstatement, that respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the allegations and Causes for Discipline contained in the Second Amended Accusation in Case No.17 2001 126714 will be deemed to be true, correct and admitted by respondent when the division determines whether to grant or deny the petition. Respondent agrees that he will not petition for reinstatement for at least three years following the effective date of this decision. Respondent hereby waives any time-based defense he might otherwise have to the charges contained in the Accusation in Case No. 17 2001 126714 including, but not limited to, the equitable defense of laches.

14. The parties agree that facsimile copies of this Stipulation for Surrender of License, including facsimile signatures on it, shall have the same force and effect as the original Stipulation for Surrender of License.

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ACCEPTANCE

I, James I. Honda, M.D., have carefully read the above stipulation and enter into it freely and voluntarily and, with full knowledge of its force and effect, do hereby agree to surrender my physician's and surgeon's certificate, No. A 21748, to the Division of Medical Quality, Medical Board of California for its formal acceptance. By signing this stipulation to surrender my license, I recognize that I will lose all rights and privileges to practice as a physician and surgeon in the State of California.

DATED: 12 Jan 2008.

JAMES I. HONDA, M.D.
Respondent

I have read and fully discussed with respondent James I. Honda, M.D. the terms and conditions and other matters contained in the above Stipulation for Surrender of License. I approve the form of this Stipulation.

DATED: 23 Jan 2008.

STACY K. BRIGHAM
DAVIS, GRASS, GOLDSTEIN & HOUSOUER
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California,

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Department of Consumer Affairs.

DATED: 2/13/08.

EDMUND G. BROWN JR., Attorney General
of the State of California

DAVID CARR
Deputy Attorney General

Attorneys for Complainant

Exhibit A:

Second Amended Accusation; Case No. 04 2005 164544

BILL LOCKYER, Attorney General
of the State of California
JOSE GUERRERO,
Supervising Deputy Attorney General
DAVID CARR, State Bar No. 131672
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California Department of Justice
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMES I. HONDA, M. D.** 1321 North Harbor Boulevard, Suite 202 Fullerton, CA 92835 Physician's and Surgeon's Certificate No. A 21748 Respondent.	Case No. 17-2001-126714 OAH No. L 2002 120496 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 6, 1965, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 21748 to James I. Honda, M.D. (Respondent). The Certificate was in full force and effect at all times relevant to the allegations of this Accusation and will expire on September 30, 2008, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Board's Division

of Medical Quality, under the authority of the following laws.[1]

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

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1. All section references are to the Business and Professions Code unless otherwise indicated.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Pursuant to section 3502 of the Code, medical services performed by a physician assistant must be performed "under the supervision of a licensed physician and surgeon. . ." Section 3501, subdivision (f), of the Code provides that "'[s]upervision' means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant."

9. Title 16, California Code of Regulations, section 1399.545(g) provides that a supervising physician has continuing responsibility to follow the progress of a patient treated by a physician assistant whom the physician is supervising, and further provides that the supervising physician is responsible for all medical services provided by a physician assistant under his or her supervision.

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FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

10. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he was repeatedly negligent in his care and treatment of patients Walter B., Thomas C., Timothy D., Darrell H., Rodney H., Raymond H., Miria L., and Yvette P.[2]

11. The negligent care and treatment of the patients listed in paragraph 10 above was rendered by Physician's Assistant Joycelyn Gordon ("Gordon") and/or Respondent at the Mercy Family Medical Center ("MFMC") located at 5763 Pico Boulevard in the City of Los Angeles. Gordon was supervised by Respondent, and Gordon's negligence is therefore imputed to Respondent pursuant to section 3502, subdivision (f), of the Code; and Title 16, California Code of Regulations, section 1399.656(g).

12. On or about August 6, 2001, the California Department of Health Services conducted an unannounced office visit to MFMC. Thereafter, the Department of Health Services received from MFMC the patient charts for the patients listed in paragraph 11 above. These records will be referred to hereinafter as the DHS records.

Walter B.

13. Patient W.B. was first seen by Gordon on July 6, 2001. One of the diagnoses made by Gordon on this occasion was "chest pain, rule out angina/tachycardia." There is no notation in the patient record as to the history of the chest pain. Gordon did not order a treadmill stress test. Gordon's evaluation of Walter B.'s possible angina constituted a departure from the standard of care.

14. On July 6, 2001, Gordon ordered blood tests for Walter B. The blood test results indicated that Walter B. was anemic. Thereafter, further evaluation of Walter B.'s anemia should have been conducted, and should have included blood testing for iron deficiency,

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2. The full names of the patients will be disclosed to Respondent upon a timely request for discovery.

folate deficiency, Vitamin B12 deficiency, and possible occult blood loss. Gordon's failure to do these follow-up tests constituted a departure from the standard of care.

15. Gordon ordered spirometry for Walter B. on or about July 6, 2001. The spirometry results were reviewed by Gordon on or about July 9, 2001. On or about March 8, 2002, the Medical Board of California received a copy of Walter B.'s medical record from Respondent. Included in the record was a copy of the spirometry results. On that document the words "treat [with] albuterol" are handwritten. This entry was made by Respondent, at Respondent's direction, or under Respondent's supervision. This entry does not appear in the DHS records. The addition of this entry to Walter B.'s medical record without any notation that it was a late entry constituted a departure from the standard of care.

Thomas C.

16. Patient Thomas C. was first seen by Gordon on or about July 16, 2001. Thomas C. reported that he had smoked one-half pack of cigarettes per day for 30 years, and that he had had asthma for the past 10 years. Gordon's examination of Thomas C.'s lungs revealed bilateral rales and rhonchi. Gordon ordered spirometry for the patient, but did not order a chest X-ray. Failure to order a chest X-ray constituted a departure from the standard of care.

Timothy D.

17. Patient Timothy D. was first seen by Gordon on or about July 9, 2001. Timothy D. reported that he had smoked one pack of cigarettes per day for 30 years, and suffered from chronic cough and shortness of breath. Gordon failed to order a chest x-ray for Timothy D. This failure constituted a departure from the standard of care.

18. Spirometry ordered by Gordon on July 9, 2001, indicated that there was improvement post bronchodilator. Nevertheless, Gordon failed to order a bronchodilator for Timothy D. This failure constituted a departure from the standard of care.

19. On July 9, 2001, Gordon noted that Timothy D. had a heart murmur, and ordered an echocardiogram. The echocardiogram revealed abnormalities. There is no indication that Respondent reviewed the echocardiogram. There is no documentation that Respondent or Gordon considered further evaluation or treatment of the cardiac abnormalities. These omissions

constituted a departure from the standard of care.

20. On or about March 8, 2002, the Medical Board of California received a copy of Timothy D.'s medical record from Respondent. Included in the record was a copy of the spirometry results. On that document the word "Albuterol" is handwritten. This entry does not appear in the DHS records. This entry was made by Respondent, at Respondent's direction, or under Respondent's supervision. The addition of this entry to Timothy D.'s medical record without any notation that it was a late entry constituted a departure from the standard of care.

Darrell H.

21. Patient Darrell H. was first seen by Gordon on or about July 10, 2001.

22. On or about March 8, 2002, the Medical Board of California received a copy of Darrell H.'s medical record from Respondent. Included in the record was a copy of the results of spirometry performed on Darrell H. on or about July 10, 2001. On that document the word "severe" is handwritten next to the words "moderate chest restriction." This entry ("severe") was made by Respondent, at Respondent's direction, or under Respondent's supervision. This entry does not appear in the DHS records. The addition of this entry to Darrell H.'s medical record without any notation that it was a late entry constituted a departure from the standard of care.

Rodney H.

23. Patient Rodney H. was first seen by Gordon on or about July 17, 2001. Rodney H. reported that he had substernal chest pain brought on by exertion. The pain was described as a sudden tightness lasting 2 or 3 minutes that was relieved by rest after a few moments. Rodney H. reported a history of hypertension. A heart murmur was found on physical examination. Gordon's assessment included "rule out angina." Gordon ordered an EKG, which was performed on or about July 17, 2001, and yielded "borderline normal" results. Further evaluation of the Rodney H.'s cardiac condition, such as a treadmill stress test or referral to a cardiologist, should have been done, but was not done. The failure to perform further evaluation of Rodney H.'s cardiac condition constituted a departure from the standard of care.

24. On or about July 17, 2001, Gordon ordered HIV and hepatitis blood tests

for Rodney H. These tests yielded positive results for HIV and hepatitis C. The HIV positive test results bear the handwritten notation "notify patient ASAP," and an indication that a "return to clinic" letter was mailed. However, the patient records do not indicate that Rodney H. was in fact notified of the HIV and hepatitis C positive results. Nor do the patient records indicate that Rodney H. was advised as to the need for further evaluation and therapy. The failure to notify Rodney H. of the HIV and hepatitis C positive test results and the failure to advise him as to the need for further evaluation and therapy constituted a departure from the standard of care.

Raymond H.

25. Patient Raymond H. was first seen by Gordon on or about July 19, 2001. Gordon's assessment of Raymond H. was, in part, "rule out angina." Gordon did not order a treadmill stress test, and did not refer Raymond H. to a cardiologist. The evaluation of possible angina in Raymond H. constituted a departure from the standard of care.

26. Gordon's assessment on July 19, 2001, also included "suspect GERD [gastroesophageal reflux disease]." On December 14, 2001, Gordon again saw Raymond H. At this time Gordon suggested triple antibody therapy to Raymond H. and continued the patient on Mylanta. The evaluation of GERD in a patient is based mainly on the patient's history. If the history is consistent with GERD, there are various courses of action that may be taken, including a therapeutic trial of medicine, a barium swallow to evaluate for reflux or ulcers, or a referral to a gastroenterologist. Gordon took none of these courses of action. The evaluation and treatment of Raymond's suspected GERD constituted a departure from the standard of care.

27. On July 19, 2001, Raymond H. reported that he smoked one pack of cigarettes per day, and experienced a chronic cough, shortness of breath, wheezing, and difficulty breathing. Physical examination revealed a heart murmur. Gordon's assessment was, in part, "rule out COPD." Gordon ordered spirometry, but did not order a chest X-ray. Failure to order a chest X-ray constituted a departure from the standard of care.

Miria L.

28. Patient Miria L. was first seen by Gordon on or about July 19, 2001. The patient reported that she had smoked one pack of cigarettes per day for the last 13 years. She

complained of chest pressure or pain. A cardiac murmur was noted on physical examination. Hypertension was documented. Gordon's assessment included "rule out angina." Gordon ordered an EKG, which yielded an abnormal result. There is a notation on the EKG: "Refer for stress test." An echocardiogram done on July 19, 2001, yielded abnormal results. The echocardiogram report bears the handwritten notation: "Refer to cardiology." However, there is no documentation that a stress test or referral to cardiology were actually accomplished. The management of Patient Miria L.'s possible angina constituted a departure from the standard of care.

29. Gordon's assessment on July 19, 2001, included "suspect GERD." Gordon failed to order a therapeutic trial of medicine, a barium swallow to evaluate for reflux or ulcers, or a referral to a gastroenterologist. The evaluation and treatment of Miria L.'s suspected GERD constituted a departure from the standard of care.

Yvette P.

30. Patient Yvette P. was first seen by Gordon on or about July 3, 2001. The 35-year-old patient indicated that she had smoked for 15 years, and had had asthma for 10 years. She complained of chronic cough, shortness of breath, and wheezing. Gordon ordered spirometry on July 3, 2001, which showed marked improvement post-bronchodilator. However, Gordon did not order a chest X-ray. The failure to order a chest X-ray constituted a departure from the standard of care.

31. On July 3, 2001, Yvette P. complained joint pain in legs, hand and lower back. Gordon ordered blood tests, which yielded a positive rheumatoid factor and an elevated sedimentation rate. There is no indication in the patient's record that she was notified of these results, or that she was referred to a rheumatologist. The failure to notify Yvette P. of the possibility of rheumatoid arthritis, and the failure to refer her for further evaluation and therapy, constituted a departure from the standard of care.

32. On July 3, 2001, Yvette P. indicated that she was taking Lotrel, apparently for high blood pressure. The blood tests administered on July 3, 2001, indicated an elevated blood urea nitrogen (BUN) level. Lotrel contains benazepril, which can elevate BUN.

Yvette P. should have been advised to alter her intake of Lotrel, in light of the BUN results. The failure to so advise Yvette P. constituted a departure from the standard of care.

33. The blood tests administered on July 3, 2001, indicated that Yvette P. was anemic. Although there is a handwritten notation stating "anemia profile" on a laboratory report, there is no indication in the medical record that an anemia profile was in fact ordered. Nor is there any indication in Yvette P.'s record that the patient was notified of her anemia. The failure to perform further evaluation of Yvette P.'s anemia, and to provide therapy for the anemia, constituted a departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence–Walter B.)

34. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Walter B. The circumstances are as follows.

35. The allegations contained in paragraphs 12-15 and 17 above are re-alleged at this point.

36. The addition of the words "treat [with] albuterol" to Walter B.'s medical record without any notation that it was a late entry constituted an extreme departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence–Thomas C.)

37. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of patient Thomas C. The circumstances are as follows.

38. The allegations contained in paragraph 12-14, and 18 above are re-alleged at this point.

39. Failure to order a chest X-ray of Thomas C. constituted an extreme departure from the standard of care.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence–Timothy D.)

40. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Timothy D. The circumstances are as follows.

41. The allegations contained in paragraph 12-14 and 19 above are re-alleged at this point.

42. The failure to order a chest X-ray of Timothy D. constituted an extreme departure from the standard of care.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence–Timothy D.)

43. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Timothy D. The circumstances are as follows.

44. The allegations contained in paragraphs 12-14, 19, 20, and 22 above are re-alleged at this point.

45. The addition of the word "Albuterol" to Timothy D.'s medical record without any notation that it was a late entry constituted an extreme departure from the standard of care.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence–Darrell H.)

46. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Darrell H. The circumstances are as follows.

47. The allegations contained in paragraphs 12-14, 23 and 24 above are re-alleged at this point.

48. The addition of the word "severe" to Darrell H.'s medical record without any notation that it was a late entry constituted an extreme departure from the standard of care.

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence–Rodney H.)

49. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Rodney H. The circumstances are as follows.

50. The allegations contained in paragraphs 12-14, and 25 above are re-alleged at this point.

51. The failure to perform further evaluation of Rodney H.'s cardiac condition constituted an extreme departure from the standard of care.

EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence–Rodney H.)

52. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Rodney H. The circumstances are as follows.

53. The allegations contained in paragraphs 12-14 and 25-26 above are re-alleged at this point.

54. The failure to notify Rodney H. of the HIV and hepatitis C positive test results and the failure to advise him as to the need for further evaluation and therapy constituted an extreme departure from the standard of care.

NINTH CAUSE FOR DISCIPLINE

(Gross Negligence–Raymond H.)

55. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Raymond H The circumstances are as follows.

56. The allegations contained in paragraphs 12-14, 27 and 29 above are re-alleged at this point.

57. Failure to order a chest X-ray of Raymond H. constituted an extreme departure from the standard of care.

TENTH CAUSE FOR DISCIPLINE

(Gross Negligence–Miria L.)

58. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Miria L. The circumstances are as follows.

59. The allegations contained in paragraphs 12-14 and 30 above are re-alleged at this point.

60. The management of Miria L.'s possible angina constituted an extreme departure from the standard of care.

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence–Yvette P.)

61. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Yvette P. The circumstances are as follows.

62. The allegations contained in paragraphs 12-14 and 32-33 above are re-alleged at this point.

63. The failure to notify Yvette P. of the possibility of rheumatoid arthritis, and the failure to refer her for further evaluation and therapy, constituted an extreme departure from the standard of care.

TWELFTH CAUSE FOR DISCIPLINE

(Gross Negligence–Yvette P.)

64. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patient Yvette P. The circumstances are as follows.

65. The allegations contained in paragraphs 12-14, 32, and 34 above are re-alleged at this point.

66. In light of the BUN results Yvette P. should have been advised to alter her intake of Lotrel. The failure to so advise Yvette P. constituted an extreme departure from the

standard of care.

THIRTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts - Ashley S.)

67. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he committed repeated negligent acts in the care and treatment of patient Ashley S. The circumstances are as follows:

68. On or about November 16, 1995, patient Ashley S. was born. The patient was born with Erb Palsy.[3] Respondent was the patient's pediatrician shortly after the patient's birth until June 3, 1997. No further documentation of the patient's Erb Palsy was noted.

69. Patient Ashley S. was first seen by respondent on or about November 27, 1995. Respondent did not document the side of the palsy and failed to document parental information and family history.

70. The patient was subsequently seen by respondent for "well child" visits on eight occasions; at 11 days of life, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months and 18 months. The "well-child" visits are represented in the medical record by a stamped standard exam which included a pediatric examination of the extremities. With the exception at 18 months, the examinations were noted as normal. No documentation of the patient's hips are recorded. No abnormal findings of the hips or extremities were documented.

71. Patient Ashley S. was also seen by respondent on or about twelve other occasions between November 1995 and June 3, 1997, for "sick" visits of varying complaints. No abnormal findings at the level of the hips or the lower extremities were documented.

72. The patient began to walk at 14 months of age. The patient's mother reported observing an abnormal gait to respondent on or about March 26, 1997. Respondent failed to record the patient's mother's observation in the patient's record. Respondent also did not note any abnormalities with the patient's extremities.

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3. Erb's Palsy: paralysis of the arm resulting from injury to the brachial plexus (usually during childbirth)

73. On May 4, 1997, the patient presented to the emergency room at St. Jude's Medical Center. The patient's mother gave a history of unsteady gait and possible antormality of the patient's lower legs since near birth. It was noted that "[s]he has brought this to the attention of the pediatrician in the past." The physical examination revealed a limp and a palpable left hip click. X-ray revealed a "dislocated right hip" and "right dysplastic acetablulum." A diagnosis of developmental dysplasia of the right hip was made.

74. On May 9, 1997, the patient was seen by respondent who noted the right hip dislocation and cast.

75. On May 23, 1997, the patient was seen again by respondent for her "well-child" examination. A spine abnormality was marked as present. However, no abnormality was noted on the extremities exam.

76. On June 3, 1997, the patient was again seen by respondent with complaint that her "hip still hurts" and legs and toes cramping. The patient's mother also noted that the patient will not walk or stand. This was the patient's last visit with respondent.

77. The patient subsequently underwent three separate surgical operations for treatment of her condition.

78. Respondent's care and treatment of patient Ashley S., departed from the standard of practice, in that:

79. He failed to appropriately assess the patient's hips;

80. He failed to diagnose the patient's developmental dysplasia of the hip.

FOURTEENTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

81. Respondent is subject to disciplinary action under section 2266 of the Code in that respondent failed to maintain adequate records in his care and treatment of patient Ashley. S. The circumstances are as follows:

82. Complainant incorporates by reference paragraphs 17, 22, 24, and 26 as if fully set forth herein.

83. Complainant incorporates by reference paragraphs 69-82, as if fully set forth herein.

84. On May 2, 2004, respondent's medical records for patient Ashley S. were sent to the Medical Board of California by the patient's attorney. A comparison of the records sent by the attorney and certified records submitted by respondent on July 29, 2002, revealed alterations consisting of the addition of a signature to each one of the notes, which were not present in the records submitted by the attorney.

FIFTEENTH CAUSE FOR DISCIPLINE

(Alteration of Medical Record)

85. Respondent is subject to disciplinary action under section 2262 of the Code in that respondent altered medical records in this matter. The circumstances are as follows:

86. Complainant incorporates by reference paragraphs 17, 22, 24, and 26 as if fully set forth herein.

87. Complainant incorporates by reference paragraph 86, as if fully set forth herein.

SIXTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

88. Respondent is subject to disciplinary action under section 2234 (b) in that he committed gross negligence in his care and treatment of patient S.V. The circumstances are as follows:

A. On or about January 17, 2005, respondent evaluated female patient S.V., who was four months old at the time. Patient S.V. presented with a 105 degree fever and irritability for 3 days.

B. Respondent failed to weigh and/or document the weight of patient S.V. on January 17, 2005.

C. Failed to adequately document the patient's history.

D. Respondent failed to perform and/or document an adequate neurologic exam.

E. Respondent recommended an inadequate dose of Tylenol, 0.4 ml. PO Q4h, for a baby that weighed 15 pounds 5 ounces six days earlier. The dose should have been 0.8 ml, twice as much.

F. Respondent recommended the infant, who was not vomiting or having diarrhea, should be taken off breast milk to avoid vomiting.

G. Respondent failed to obtain appropriate laboratory tests to rule out bacterial infection.

H. Respondent failed to take adequate measures to exclude a diagnosis of a serious infection.

I. On January 18, 2005, patient S.V. was seen by another physician who diagnosed her as having a urinary tract infection. A urinalysis collected that day showed greater than 100,000 organisms/ml of the bacteria escherichia coli.

89. Respondent committed gross negligence in his care and treatment of patient S.V. by failing to obtain appropriate tests to rule out bacterial infection.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

90. Respondent is subject to disciplinary action under section 2234 (c) in that he committed repeated negligent acts regarding his care and treatment of patient S.V. as more fully set forth in Paragraph 88, incorporated by reference, in that respondent:

A. Failed to obtain a weight on an obviously ill child in order to compare the weight with the previous weight obtained 6 days earlier;

B. Failed to adequate document patient S.V.'s history;

C. Failed to perform and/or document an adequate neurologic exam; and

D. Failed to obtain appropriate tests, including, at a minimum, a CBC (complete blood count), blood culture, and urine culture to rule out bacterial infection.

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EIGHTEENTH CAUSE FOR DISCIPLINE

(Incompetence)

91. Respondent is subject to disciplinary action under section 2234(d) in that he demonstrated incompetence in his care and treatment of patient S.V. as more fully set forth in Paragraphs 88 through 90, which are incorporated by reference.

NINETEENTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records)

92. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records in connection with his care and treatment of patient S.V. as more fully set forth in Paragraphs 88 through 90, incorporated by reference, in that he:

A. Failed to adequately and accurately document patient S.V.'s weight;

B. Failed to adequately and accurately document the patient's history; and

C. Failed to adequately and accurately document a physical examination, specifically a neurologic exam.

TWENTIETH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

93. Respondent is subject to disciplinary action under section 2234 of the Code in that respondent engaged in unprofessional conduct in the care and treatment of multiple patients.

94. Complainant incorporates by reference paragraphs 12 through 35, as if fully set forth herein; and

95. Complainant incorporates by reference paragraphs 69-82, as if fully set forth herein; and

96. Complainant incorporates by reference paragraphs 83-86, as if fully set forth herein; and

98. Complainant incorporates by reference paragraphs 89-92, as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A21748, issued to JAMES I. HONDA, M.D.;

2. Revoking, suspending or denying approval of JAMES I. HONDA, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. If placed on probation, ordering JAMES I. HONDA, M.D. to pay the Division the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: August 31, 2006

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant